Title II of the Americans with Disabilities Act
COMPLAINT FORM

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 3.

Complainant:

_____

Address:

_____

City, State and Zip Code:

_____

Telephone: Home: _____

Business: _____

Person Making the Complaint:
(if other than the complainant)

_____

Address:

_____

City, State, and Zip Code:

_____

Telephone: Home: _____

Business: _____

Department/Agency which you believe has discriminated:

Name:

_____

Address:

_____

County:

_____

City:

_____

State and Zip Code:

Telephone Number:

When did the event occur? Date:

Describe the event providing the name(s) where possible for the individuals who were involved (use space on page 3 if necessary):

Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other Federal agency or court?

Yes_____ No_____

If yes:

Agency or Court:

Contact Person:

Address:

City, State, and Zip Code:

Telephone Number:

Date Filed:

Do you intend to file with another agency or court?

Yes_____ No_____

Agency or Court:

Address:

City, State and Zip Code:

Telephone Number:

Additional space for answers:

Signature: _____

Date: _____

Return to:

Joel Hoffman
State of Michigan
DIT/DMB Human Resources
Lewis Cass Building
320 S Walnut Street
Lansing, MI 48933
Phone: (517) 241-2890
Fax: (517) 241-0566